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ARBITRATION

Claimant,

v.

Respondent.

CASE NO:

ARBITRATION AWARD AND STATEMENT OF DECISION

The matter was heard by the following panel of arbitrators: Helen Culiner, claimant's designated arbitrator, Louis O'Neill, respondents' designated arbitrator, and The Honorable Roy Wonder (Judge retired), the neutral arbitrator, agreed upon by both sides. Esq. appeared on behalf of claimant. Esq., appeared on behalf of respondents. Evidence, both oral and documentary, was submitted.

I. With respect to the issue whether respondents violated the standard of care, thus causing claimant's injuries and damages, the arbitrators' decision is that respondents violated the standard of care, causing injuries to the claimant, resulting in monetary damages due him in the amount of $75,000 in non-economic damages for pain and suffering and $108,000 for economic damages for a total award of $183,000. The arbitrators base their decision on the following facts:

1. was born on . In February 1972 he had a motor vehicle accident, resulting in quadriplegia at the C5-6 level. He graduated from graduating on the honor roll, in 1973. In 1982 he became a full-time student at earning his AA in degree in 1984. He then went on to earn his BA in psychology from in 1987, focusing on human services.

From 1987 to 1989 he worked at , teaching and counseling students.

2. In 1989 he got a job with the . He worked for it in rom 1989 to 1991 and in) from March 1991 to December 1994. He ceased working for the department on December 20, 1994, when the incident giving rise to his claim in this matter arose. He has not returned to work. He was terminated by the in July 1995. His work at the , a 26.50-hour a week job, involved about 25% of his time meeting with applicants, and 75% doing clerical and networking work. He had an office at and one at He traveled back and forth between the offices and to various meetings around the Bay Area in connection with his work. He drove himself in a wheelchair accessible van. These meetings took him to Los Angeles, San Jose, and Sacramento.

3. During that time period his social activities included dinner parties, movies, visiting friends, trips to Ocean Beach where he sat and read, and visits to his mother and sister in Santa Rosa.

4. On November 7, 1994 claimant had an appointment with his primary care physician at He presented with a history of "tightness in his chest, past two to three weeks, not coughing, but hasn't been able to breathe easily." The doctor measured his peak flow rate and found that it was a 175; whereas, it had been 350 cc. His pulse was normal. He had decreased breath sounds. The right lower lobe (of his right lung) was flat to percussion. He diagnosed a "possible pneumonia," and he prescribed erythromycin 250 ml four times a day. He told claimant to "call in four days."

5. Claimant called back and left a message on December 6, 1994: "seen before Thanksgiving, -antibiotic for upper respiratory infection- erythromycin 10days, finished 12/1- short of breath, without congestion-hard to breathe and hard to talk-inhaler using Madipul." Under the symptom section of the message form, the nurse wrote "no fever-pulmo (indecipherable) help. Still has difficulty breathing-short of breath - - not audible over phone-patient speaking with ease over phone." The triage plan conveyed by the nurse was "patient declines appointment-regular MD to advise - feels madipul inhaler

causing 'burning' on use in chest- causing respiratory difficulty even when upright - requests change inhaler." The nurse ordered the claimant's chart. She gave the chart to , who was covering for The nurse made the following note, after consulting with and speaking with the claimant by phone: "patient notified per (indecipherable) to be seen for respiratory problem - patient declined an appointment today with urgent medical care doctor-prefers tomorrow- back on 12/7- will call patient back to book after 2:00 p.m."

6. The nurse called claimant back by phone on December 7 and made the following note: "notifies patient-consulted with -he will call patient tomorrow a.m.-rather then book appointment. Patient advised to call back if treatment worsens - he is aware if (indecipherable) acute to go to emergency room." wrote, with respect to claimant's inhaler "change to Ventolin."

7. On December 12, 1994, claimant called The nurse made the following message: "Albuterol inhaler - not working- helps a little-

1) uses it hourly- wakes up in middle of night short of breath then has to take a lot of medicine. Directions four times a day on box - but using every hour-

2) no coughing - the urge is there all the time. No congestion. No fever

3) patient requests MD to advise - he is at work."

wrote an order: "trial Prednisone (dosage and duration indecipherable) call two days."

8. Claimant went to the emergency room on December 21, 1994. He was treated there by , who then became his primary care physician. He was diagnosed with a pleural effusion. He was admitted to the hospital where he remained until December 26, 1994. While hospitalized he had three thoracenteses. In the first procedure one and one half liters of pleural fluid were drained; in the second, one liter was drained; an additional unspecified amount was removed in the third procedure.

9. He returned to the hospital on January 6, 1995 and had a pleural biopsy.

10. He returned to the hospital on January 10, 1995 for another thoracentesis.

11. He returned on January 13, 1995 and was admitted by because of his deteriorating condition. On January 17, 1995 he had a right thoracotomy and pleurodesis. He was finally discharged on January 26, 1995.

12. After his discharge, he recovered at home. He was in a very debilitated state of health at that time. As a result of his debilitated state, he was susceptible to pressure sores and decubitii. He also became chronically depressed, as result of his deteriorated physical condition. While trying to avoid the pain caused by the pressure sores and decubitii, he developed a problem with the pain medication Percocet. In June and July 1995, he had necrotic matter removed from decubitii in his right chest and right ischial tuberosity. He also had appointments with a psychologist for his depression. As result of his depression and pain, he ate inadequately and his nutrition suffered, resulting in even greater debilitation. In June or July 1995, his pressure sores developed into decubitii, requiring debridment of necrotic matter at Finally, on August 1, 1995 he returned to by ambulance. His decubitii were debrided again, and he was treated for a urinary tract infection. He was discharged to a skilled nursing facility.

13. In the skilled nursing facility, the sphincterotomy, which he had had performed in 1984, failed, resulting in a vesicocutaneous fistula. As a result, urine was draining out a hole in his abdomen. This situation resulted in his frequently having to sleep in his urine.

14. He was transported back to where the fistula was treated primarily by the placement of a Foley catheter, permitting the bladder to be continuously drained, so the fistula could spontaneously heal. That hospitalization commenced on August 22, 1995 and lasted through August 31, 1995. He requested a transfer to , where his mother and sister resided. did not have surgical facilities to treat his decubitii, so he was transferred instead to

15. He arrived by amublance at on September 1, 1995. He was at from September 1, 1995 through his discharge on October 3, 1995. While there, a cystoscopy was performed. The impression was that the sphincterotomy had failed. The decubitius on his ischial tuberosity was debrided again, and a skin flap procedure was performed. The decubitus on his right chest wall was also debrided, and a skin graft was performed to cover the wound. His nutritional status was extremely poor,

because of his inability to take food by mouth. To treat his nuturitional problem a gastrotomy tube was surgically placed in his stomach to get nutrition directly into his system.

16. Upon his discharge on October 3, 1995 he went to the where he remained until November 17, 1995. He was discharged to a skilled nursing facility, where he remained until his discharge on January 13, 1996.

17. Claimant has not been re-hospitalized since that time. On March 11, 1996, he had the Foley catheter removed and a supra pubic catheter surgically installed.

18. As a result of the hospitalizations, the surgery, the chronic pain, and the depression, claimant was not able to return to work until sometime between the summer of 1996 when he was offered employment at the of and the fall of 1997 when he was offered a position with the same department in near his home. He turned the offers down.

19. The standard of care was violated by the respondent with respect to claimant's pulmonary care in the following ways:

1) When claimant presented on November 7, 1994, he was not given a chest x-ray, and he was not given a follow-up appointment in approximately one week to determine whether he was making progress with the antibiotic or not.

2). When he called in on December 6, 1994, reporting he had finished the antibiotic on December 1, 1994, well after the ten days prescribed, had shortness of breath, that it was hard for him to breathe and hard to talk, should have booked an appointment for him, examined him and ordered a chest x-ray. Simply telling the patient to call back if the treatment worsens, fell below the standard of care.

3). When the claimant called in on December 12, 1994 and reported that his inhaler was not working, even though he used it hourly, that he was waking up in the middle of the night short of breath and then had to take a lot of medicine, that even though the directions on the inhaler said to use it four times a day, he was having to use it every hour, that the urge to cough was there all the time, an appointment

should have been scheduled, physical exam conducted, and a chest x-ray ordered. Simply prescribing Prednisone over the telephone fell below the standard of care.

20. Claimant was likely suffering from pneumonia in November and December 1994. If claimant had been properly treated within the standard of care during that time period, he would have likely been able to have been treated with antibiotics and/or out-patient thoracentesis only. As a result of not being treated within the standard of care, he was required to undergo two hospitalizations and a thoracotomy and pleurodesis. The hospitalizations and the extensive pulmonary surgical procedures resulted in claimant becoming debilitated, depressed, and unable to have sufficient nutrition.

21. The respondents' negligence is a substantial factor, and therefore the cause, for claimant being unable to work between December 20, 1994 and the fall of 1997, his pain and suffering and his substantial loss of enjoyment of life.

22. Claimant filed his demand for arbitration within one year of discovery of the negligent cause of his injuries but for his claim of decubitii.

23. Claimant's pain and suffering and loss of enjoyment of life for his injuries caused by the violations of the standard of care are is $75,000.

24. Claimant's financial, out-of-pocket losses, caused by his injuries which were caused by respondents' violations of the standard of care are $108,000 for lost income.

The arbitrators hereby award to claimant the sum of $183,000.00

Dated:

HELEN CULINER
Arbitrator

Dated:

JUDGE ROY WONDER (retired)
Arbitrator

I dissent:

Dated:

LOUIS O'NEAL
Arbitrator